VERIFICATION UNDER OATH

STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: Kahm Clinic IOP-PHP
Eating Disorder Treatment Program
GMCB-009-21con

Verification Under Oath

Nicholas Kahm, being duly sworn, states on oath as follows:

1. I am the Chief Executive Officer of Kahm Clinic IOP-PHP, LLC. I have reviewed the Certificate of Need Application (Application) to begin an IOP-PHP eating disorder treatment program.

2. Based on my personal knowledge, and after diligent inquiry, I attest that the information contained in the Answers to First Set of Questions is true, accurate and complete and does not contain any untrue statement of a material fact, and does not omit to state a material fact.

3. My personal knowledge of the truth, accuracy and completeness of the information contained in the Application is based on my actual knowledge of the subject information or upon information reasonably believed to be true and reliable to me (for example information in published articles).

4. In the event that the information contained in the Application becomes untrue, in accurate or incomplete in any material respect, I acknowledge my obligation to notify the Green Mountain Care Board as soon as I know that the information or document has become untrue, inaccurate or incomplete in any material respect.

Nicholas Kahm

On April 5th, 2022 Nicholas Kahm appeared before me and swore to the truth, accuracy and completeness of the foregoing.

Notary Public Sayuri Koerner

My Commission expires 01/31/2023
157.0012803

1. Provide a detailed description of your contacts with Vermont Medicaid, the dates of contact, and the content of what was discussed. Provide copies of all documents you submitted to Vermont Medicaid. This must include requests made for reimbursement rates and codes submitted for both the PHP and the IOP programs and specify whether the rates you requested included or excluded the charges per appointment and/or per week for the Metabolic Testing device and the Body Composition device. If not, please explain why the charges for the two devices were not included in the requested Medicaid rate.

I have reached out to Medicaid about the day rates for IOP and PHP treatment. I have not yet enquired about the rates for Metabolic Testing and Body Composition Analysis because the decision to go in network with Medicaid depends on the day rates.

On Feb 4th, 2001, after I received the second round of questions which included the correct contact information for DVHA I reached out to Medicaid and asked about the day rates for PHP and IOP treatment.

On Feb 8th, they acknowledged that they had received my email.

On Feb. 9th, they sent me their actual rates, which were as low as I was expecting.

Later on Feb. 9th, I responded thanking them for the email and letting them know I would reach out when I was ready.

On April 4th, I sent Medicaid a document (attached, the actual rates are blocked out, as they are trade secrets for negotiation), which used much of the material from the CON application to argue for and request higher rates.

Later on April 4th, Medicaid responded and asked me if there were any additional services that would require rate negotiation. Immediately afterwards, I received this last round of questions asking whether I had included the metabolic testing and body composition analysis in my discussion with Medicaid.

2. Provide a detailed explanation as to whether you will or will not accept Medicaid members and the reasons behind your decision.

Our answer to this question has not changed since we submitted the application.

We are deeply concerned about the access of low-income Vermonters who have Medicaid. This is, sadly, a huge systemic issue that we have very little ability to impact. Nationally, there are very few IOP, PHP, and residential programs that accept Medicaid because they do not pay enough to cover costs. As things stand now, Vermonters with Medicaid generally go to Walden in the Boston Area, which is one of the few places in the country that does take VT Medicaid (I would love to know what rates have been negotiated with them).

I have started negotiating with Medicaid and hope that they can sufficiently raise their rates. However, what exactly an acceptable Medicaid rate is depends on what the private insurers will pay. And I cannot know that until months after the CON is issued, should it be issued. The rates from the private insurers need to be high enough to subsidize taking the loss on Medicaid patients. And, of course, another factor here is how well we are able to keep our costs under control granting rampant inflation. Businesses usually look good on paper prior to the start, but starting a business is always risky and one never really knows what it will be until one actually creates it. I am asking that you give me time to get the business up and running and time to see what it truly is. Then I will be able to see what we can afford without jeopardizing the whole. Then I will craft a charity policy and make the decision with Medicaid. In the meantime we can still see some Medicaid patients through single-case agreements.

If the Board mandates that we take Medicaid, we will not have much negotiating leverage with them. It is crucial in such negotiations to be able to say to an insurer that we will not sign the contract if they do not come to a reasonable rate – we have to be able to follow through on this. If we are mandated by the CON to take Medicaid, we can never do that. Also, I have been having discussions with others who have successfully negotiated with VT Medicaid and the negotiation process is apparently a very long and time consuming process – not one which will be wrapped up in the near future.

The GMBC rightly desires to make services as accessible as possible, and the Board also wishes to lower costs. If we took Medicaid, we would run a loss on every Medicaid patient. Increasing access to Medicaid patients raises the costs of this business considerably, making the entire venture more risky, so much so that I don't think I will risk the investment.

I wrote a similar response to our answers to questions 2 and 4 of the first round of questions.

SOCIAL & ECONOMIC COST OF EATING DISORDERS IN VERMONT

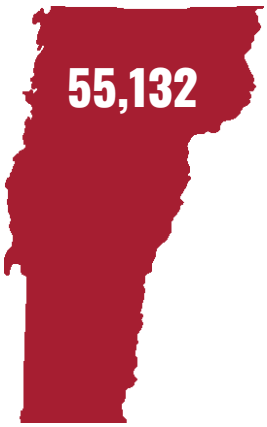
Report by the Strategic Training Initiative for the Prevention of Eating Disorders, Academy for Eating Disorders, and Deloitte Access Economics

STRIPED — A PUBLIC HEALTH INCUBATOR
Strategic Training Initiative for the Prevention of Eating Disorders

LINK TO REPORT

Academy for Eating Disorders (AED)

PREVALENCE & MORTALITY



Nine percent of Vermonters (55,132 people), will have an eating disorder in their lifetime

10,200 deaths per year nationally as a direct result of an eating disorder, equating to 1 death every 52 minutes

EATING DISORDERS AFFECT EVERYONE:

- **All ages**, starting as young as 5 years old to over 80 years old
- **All races**, however, people of color with eating disorders are half as likely to be diagnosed or to receive treatment[1]
- **All genders**, with females being 2x more likely to have an eating disorder
- **All sexual orientations**

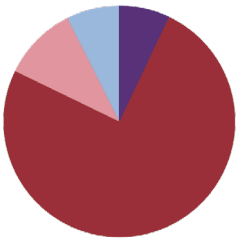
COST TO ECONOMY & SOCIETY IN VERMONT

$123.9 Million } Yearly economic cost of eating disorders

Additional loss of wellbeing per year { **$625 Million**

Cost Breakdown:

Productivity Losses ($93M)
Informal Care ($12.8M)
Efficiency Losses ($9.2M)
Health System ($8.8M)



COST TO HOSPITAL SYSTEMS:

103 ER visits

costing **$56,089**

45 inpatient hospitalizations

costing **$401,430**

LOSS PER GROUP:

$45M Individuals & Families

Caregivers provide 6 weeks of informal, unpaid care per year

$33.9M Government

$31.2M Employers

$13.6M Society

[1]Sonneville KR, Lipson SK. Disparities in eating disorder diagnosis and treatment according to weight status, race/ethnicity, socioeconomic background, and sex among college students. International Journal of Eating Disorders 2018: 1-9.
Note: State-level data are estimates based on U.S. Census Bureau population statistics (2018). Link to data.

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EDC Eating Disorders Coalition for Research, Policy & Action · NEDA Feeding hope. National Eating Disorders Association · IFEDD The International Federation of Eating Disorders · THE ALLIANCE for Eating Disorders Awareness · ANAD Your future is worth fighting for · NCEED National Center of Excellence for Eating Disorders · iaedp Foundation International Association of Eating Disorders Professionals · meda multi-service eating disorders association · F·E·A·S·T · Mentorship · Prevention · Support · Recovery · Project HEAL · REDC Residential Eating Disorders Consortium

To Whom It May Concern:

Please accept this documentation, which is a request for a special rate for IOP and PHP eating disorder services here in Vermont. We are currently going through the Certificate of Need process with the Green Mountain Care Board and they requested that I reach out to you to negotiate rates.

The Kahm Clinic is currently an outpatient nutrition clinic that specializes in eating disorders, but also sees patients for general nutritional counselling, sports nutrition, prediabetes, weight management and fatigue. We are currently in network with Medicaid. The Kahm Clinic was founded in 2016 by Nicholas and Annika Kahm in Burlington and remains family owned and operated. Since our inception we have seen a continual rise in eating disorder cases here in Vermont and we have grown more and more frustrated with the lack of adequate resources or options for care in Vermont. The limitation of options for patients with eating disorders in Vermont hinders effective treatment and recovery. We experience this daily with our patients. To address these needs we have formed a new entity named Kahm Clinic IOP-PHP, LLC (hereinafter "Kahm Clinic IOP-PHP"), and propose to offer Partial Hospitalization (PHP) and Intensive Outpatient (IOP) eating disorder treatment through that entity.

In Transforming Mental Health Care in the United States, a RAND research brief, McBain et al. (2021) found that "it is the responsibility of the health system to make sure that patients are receiving care that meets their level of need…"[1] The American Psychological Association details a hierarchy of the 5 levels of care needed to effectively treat eating disorders. Each of these levels of care corresponds to the level of need of a person's eating disorder and together they form an evidence based, staged system constituting a hierarchy of interventions, from the least to the most intensive, matched to the individual's needs. This allows patients to "step-up" or "step-down" the intensity of their treatment, so that treatment is available to meet an individual's needs at the point in time that they require such treatment. The levels are as follows:

> Level 1. Outpatient - Individual visits with specialists, often weekly depending on the specialist, who all ideally work together to coordinate care. These specialists often include a psychiatrist, therapist, primary care physician, and a dietician.
>
> Level 2. Intensive Outpatient - Multidisciplinary treatment team is on staff. Typically meets 3-4 times/week for 3 hours/day. Patients can continue working or attending school while in treatment. This includes multidisciplinary treatment with medical nutrition

[1] McBain, Ryan K., Nicole K. Eberhart, Joshua Breslau, Lori Frank, M. Audrey Burnam, Vishnupriya Kareddy, and Molly M. Simmons, Transforming Mental Health Care in the United States. Santa Monica, CA: RAND Corporation, 2021. https://www.rand.org/pubs/research_briefs/RBA889-1.html.

therapy, psychiatric treatment, individual, group, and family therapy as well as recovery skills development.

Level 3. Partial Hospitalization (Often also referred to as Day Treatment). Similar to IOP but includes more comprehensive care provided 5-7 days/week, for 6-10 hours/day. Typically includes one structured/supported meal.

Level 4. Residential 24/7 nursing care for medically stable patients. Multidisciplinary treatment, including medical, nutrition, therapy, and psychiatric treatments, the provision of therapeutic meals and snacks and individual, group and family therapy, nutrition counselling and education, and recovery skills development.

Level 5. For medically unstable patients. Hospital-based intensive multidisciplinary inpatient treatment, medical and weight stabilization often including tube or intravenous feeding, and psychiatric treatment.

There is a grave lack of eating disorder specific treatment available to Vermonters in-state. The in-state treatment programs that are available are almost exclusively at the lowest level of care, outpatient. This means that patients for whom higher levels of care are appropriate have nowhere to turn. This often results in increased severity of their eating disorder, they become sicker than they need to be, they overwhelm and wear down their outpatient providers who cannot adequately help them, they cycle in and out of the emergency room, ultimately becoming sick enough to warrant 24-hour care and sent out of state to expensive residential or inpatient treatment. Upon return from that care, they cannot step down slowly, but again only have access to outpatient treatment. This becomes a cycle, but one that can be avoided.

To fill this gap in the continuum of care, we intend to open a PHP and IOP program in Chittenden county, Vermont's most populous region, to serve Vermonters with eating disorders. This will help promote the health and well-being of Vermonters by curing and preventing the worsening of eating disorders for many, providing them with the treatment appropriate to the severity of their eating disorder, taking pressure off providers now overwhelmed with patients who are too sick, as well preventing some downstream costs, e.g., expensive 24hr residential or inpatient care, lowering ER visits, and helping people return to their jobs and schools.

Since Vermont predominantly has outpatient care, this means that patients who need care at any other rung of the ladder do not have options for the care they need and tend to ping pong between outpatient and inpatient care. Vermonters are not able to receive the right care at the right time in the right place. Because of this we are seeking a Certificate of Need to open an PHP and IOP program that will provide Vermonters the option to obtain treatment at the most effective, least restrictive therapeutic level.

Eating Disorders – A Prevalent Health Condition Lacking Vermont Treatment Options

Prevalence and Cost of Eating Disorders

Eating disorders are a prevalent health condition in general and are associated with some of the highest levels of medical and social disability of any psychiatric condition.[2] All in all, 9% of the world's population suffers from an eating disorder. Almost 1% suffer from anorexia nervosa, between 2-3% have bulimia nervosa, 2-3% have binge eating disorder, and at least 4% suffer from OSFED (other specified feeding or eating disorders).[3] 10% of those with eating disorders will die from it and 26% will attempt suicide.[4] One American dies of an eating disorder every 52 minutes. Vermont itself has a high burden of eating disorders that has increased in the COVID pandemic. See Eating disorders spiked during the pandemic; clinics are struggling to cope - VTDigger

For those of us working in the eating disorder field in Vermont, every day we confront the paucity of resources available for Vermonters who suffer from eating disorders. Since the Kahm Clinic opened its doors in 2016, we have engaged in a constant struggle to find sufficient care for those who are far too sick for regular outpatient care. By way of example, in April of this year which was a fairly typical month the Kahm Clinic saw approximately 189 patients with eating disorders, 20 of whom would benefit from PHP or IOP treatment.

The economic and social impact of eating disorders in Vermont is tremendous. A Harvard study recently estimated that in 2018-2019, the social and economic impact was $123.9 million dollars.[5] See attached one page summary of the findings. The researchers broke this down into $93 million in productivity losses, $12.8 million in informal care (care given free of charge), $9.2 million in efficiency losses (costs associated with the act of taxation and transfers, which distorts incentives and results in inefficiencies in the economy) and $8.8 million in expenses for Vermont's health care network. Of that cost, $45 million was shouldered by the individual and their families, the government paid $33.9 million of it, employers shouldered $31.2 million, and society footed $13.6 million of it. The hospital system in Vermont paid

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[2] Klump KL, Bulik CK, Kaye W, Treasure J, Tyson E. Academy for Eating Disorders Position Paper: Eating Disorders are Serious Mental Illnesses. Int J Eat Disord. 2009 Mar;42(2):97-103. doi: 10.1002/eat.20589. (This is an excellent and brief article overviewing the medical complications and social costs of eating disorders)

[3] Galmiche, M., Dechelotte, P., Lambert, G., & Tavolacci, M. P. (2019). Prevalence of eating disorders over the 2000-2018 period: a systematic literature review. *American Journal of Clinical Nutrition*, 109(5), 1402-1413; Hoek, H. W. (2016). Review of the worldwide epidemiology of eating disorders. *Current Opinion in Psychiatry,* 29(6), 336–339.

[4] Arcelus, J., Mitchell, A. J., Wales, J., & Nielsen, S. (2011). Mortality rates in patients with anorexia nervosa and other eating disorders: a meta-analysis of 36 studies. *Archives of General Psychiatry*, *68*(7), 724-731; Chesney, E., Goodwin, G. M., & Fazel, S. (2014). Risks of all-cause and suicide mortality in mental disorders: a meta-review. *World Psychiatry*, 13(2), 153-160; Udo, T., Bitley, S., & Grilo, C. M. (2019). Suicide attempts in US adults with lifetime DSM-5 eating disorders. *BMC Medicine*, 17, 120.

[5]https://cdn1.sph.harvard.edu/wp-content/uploads/sites/1267/2021/01/State-Report_Vermont.pdf

$56,089 for 103 ER visits and $401,430 for 45 inpatient hospitalizations. And according to their calculations, the additional cost of wellbeing per year was $625 million dollars.[6] Clearly, that's a tremendous impact that can be mitigated by better treatment options. Yet, despite generally good insurance coverage for treatment, there is a paucity of resources for those suffering from eating disorders.

Need for Treatment Options

It is well known in the medical field that early detection and interventions greatly improve treatment outcomes. The same applies to eating disorders (Steinhousen, 2002; Austin et. al., 2019). When patients are not being treated at the level that is appropriate for their degree of sickness, they get sicker and sicker until they actually need residential or inpatient care. The patients are deprived of the ability to work on their eating disorders while still living at home and remaining at work or school with the least interruption possible to their daily lives. Below are some patterns of typical situations encountered by Kahm Clinic patients:

- Parents who have childcare responsibilities. Often these parents can't leave home unless there is an acute inpatient need, and after that they can't participate in an out of state PHP/IOP program because of family needs. These parents, without step down care, often require additional inpatient care.
- Adolescents who leave the state for residential care and want to do step down care at home with family support but can't.
- Patients who return from inpatient stays, lose the gains from those stays outside of the inpatient structure, regressing with outpatient care and requiring their return to even longer inpatient stays.
- College students in Vermont who receive regular outpatient care but regress, are unable to maintain and are forced to go to residential or inpatient treatment, missing semesters or breaks to attend that treatment.

In 24-hour inpatient care, patients are in a completely controlled environment, where every meal is highly supervised and there is constant care and therapy. To be plucked out of this completely controlled environment and thrown back into a completely uncontrolled environment is simply too difficult for most patients. PHP and IOP programing give them a chance to still retain some of the structure while easing back into "real life." Without proper 'step down' care

[6] https://cdn1.sph.harvard.edu/wp-content/uploads/sites/1267/2020/07/Social-Economic-Cost-of-Eating-Disorders-in-US.pdf "The value of reduced wellbeing for people with EDs was also estimated. While the loss of wellbeing is not a financial cost, reduced quality of life due to impaired functioning and premature death that result from EDs was measured in monetary terms by multiplying a value of a statistical life year (VSLY) by the years of healthy life lost using the burden of disease methodology.3 Inputs for this modelling study were largely drawn from previous academic literature where greater emphasis was placed on nationally representative studies (e.g. rather than studies in insured populations alone)."

they are often unable to retain the gains achieved in 24-hour care and regress until they are back in 24-hour care.

PHP/IOP levels of care offer enhancements to outpatient therapy that provide patients much more structure than regular outpatient treatment, but they are also receiving support while working on living in their home environment and learning to cope with the things from that environment that have played a role in shaping their eating disorder. Some patients simply need more structure than regular outpatient care can offer, and a PHP/IOP program is often sufficient to help them avoid inpatient or residential care.

The use of less restrictive PHP/IOP levels of care is cost as well as clinically effective. Hayes et al. (2019), argues that PHP saves $9,645 over inpatient care. They write "Partial Hospitalization Programs are a critical part of the treatment continuum for people with eating disorders. PHPs provide an alternative to costly and restrictive inpatient and residential programs while offering more intense treatment for patients too acute for traditional outpatient services."

A PHP/IOP program will save the state of Vermont money in a number of ways:

1. Patients for whom 24hr care is too much, but outpatient is not enough, will get treated **sooner**, lowering the probability of the need for 24hr treatment. IOP or PHP may be sufficient, and they may be able to graduate to outpatient care and even be cured without ever needing 24hr care.
2. For those **stepping down** from 24hr care, they will have a place to go to retain the gains achieved in 24hr care and continue making progress. They still have a long way to go after being released from 24hr care and having a PHP/IOP will decrease the likelihood of their returning to 24hr care.
3. For those who have been **yoyoing between 24hr care and outpatient**, we hope to be able to get them off the treatment ladder altogether. But this is almost impossible without a PHP/IOP program in place.

Program Description

The Kahm Clinic IOP-PHP will offer two outpatient levels of care: Partial Hospitalization Program (PHP) and Intensive Outpatient Program (IOP). Patients will be screened by qualified staff members, in conjunction with treating outpatient providers to determine the appropriate level of care. We expect to initially run one PHP program with ten (10) patients; one evening IOP program with ten (10) patients and one day IOP program with ten (10) patients. In the third year we will run a ten (10) person adolescent IOP program. Altogether the planned initial capacity is for thirty (30) patients for the first two years and then a capacity of forty (40) in the third year. Each program, on average, is for a 12-week duration; however, this depends on clinical need, of course. To the extent we experience greater demand we will make efforts to increase capacity to provide the services.

Initially we expect that most of our patients will come from the Chittenden County area, including patients from neighboring counties. However, we are open to trying to reach Vermonters outside of that area.

Both IOP and PHP offer a structured and stable environment for individuals to work on both their physical and psychological health as they continue to face triggers and challenges in their everyday lives but with new, more evidence-based effective skills learned in programming.

IOP programming will be up to four (4) days per week for three (3) hours each day. IOP will be offered both during the day as well as in the evening to allow individuals with daytime obligations, such as work or school, the opportunity to receive treatment. A sample IOP schedule is attached. When patients are struggling with binging, purging, restricting, compulsive exercising, food rituals, etc., they are surrounded by clinicians who deeply understand eating disorders and can help provide accountability and support around stopping eating disorder behaviors and replacing them with healthy coping skills and eating habits. At the IOP level of care, patients have a meal with staff and other program participants each day of the program. This provides accountability that is otherwise absent. During these groups, staff also model healthy eating which can be a powerful example of support for patients.

PHP programming will be offered five (5) days per week for six (6) hours each day. A sample PHP schedule is attached. The PHP program differs from IOP in that program days are more frequent and the programming is longer which allows for greater structure and support. This allows for more in depth therapy groups and more support around meals/snacks and discontinuing eating disorder behaviors. For those who find IOP to be helpful, but are still in need of more support, PHP can be a helpful boost. For those who are stepping down from a higher level of care, such as residential (Level 4), PHP helps act as a retainer to preserve progress made in the residential setting while still allowing the patient to begin slowly integrating back into their normal life.

Patients who start at the PHP level of programming will be recommended to step down to IOP programming after completing PHP, and clients at the IOP level of programming will be recommended to step down to outpatient services once they have completed IOP. If an individual does not enter programming with an established outpatient team, staff will assist in setting one up prior to discharging from the program. The client's progress will be closely monitored by staff and assessed weekly in clinical staff meetings. If an individual is struggling at either level of care, a recommendation will be made to step up in level of care (PHP will be recommended to step up to RTC or inpatient program and IOP will be recommended to step up to PHP programming). Staff will assist in finding the appropriate treatment placement for an individual if it is needed.

Both PHP and IOP programs include evidence-based treatment through the use of cognitive behavioral therapy (CBT) and dialectical behavioral therapy (DBT). Clients will be exposed to both CBT and DBT in their individual sessions as well as in group therapy. Clients will receive individualized treatment based on their specific needs and goals, and this treatment

will be provided by qualified staff members. Each client will be assigned a treatment team upon admission to the program. The treatment team will consist of the clinical director, a therapist, a registered dietitian, and a medical director. Clients at the PHP level of care will receive two therapeutic sessions weekly: one with their individual therapist, one nutrition session with their dietitian. Clients at the IOP level of care will receive one therapeutic session weekly with their individual therapist, one nutrition session with their dietitian, and one consultation with the psychiatrist.

Clients will attend group therapy daily while in programming. A variety of groups will be offered and will include exposure therapy, nutrition and movement, process and didactic groups, and experiential therapy. These groups are designed to help individuals learn new and more effective ways to cope with their eating disorder thoughts and cognitions. The opportunity for group settings with others who are going through the same recovery process can be invaluable for gaining insight, hope, encouragement, and support for recovery.

Patients will have the chance to set new goals and intentions daily as well as cope ahead at the end of the program day for any foreseeable challenges outside of treatment. They will also have the chance to experience more positive interactions with food through staff supported meals and snacks, grocery store and restaurant outings, as well as in culinary groups, where they will learn culinary skills to set them up for success in preparing their own meals outside of programming. Patients will have the opportunity to process these exposures and experiences with staff and will be offered support to cope with the thoughts and urges that arise during those encounters. Some of the other groups offered will include Body Image, Relapse Prevention, Healthy Relationships, all of which will provide patients the space to work through some of the other impacts their eating disorders may have had on their lives and reduce the risk of relapse in the future. The overall goal of both PHP and IOP is to set individuals up for success on their own outside of programming helping them gain more confidence in their ability to cope with the eating disorder and every component of programming is designed to help reach that goal.

It is so widely accepted as to be axiomatic that intensive outpatient and partial hospitalization levels of care are effective at treating mental health conditions such as eating disorders. We incorporate the information already provided and provide this additional response, based on the following papers that provide ample evidence that Intermediate levels of care are necessary for effective treatment of eating disorder patients that require more than weekly outpatient visits with specialists. They include systematic literature reviews and treatment guidelines.

- The American Psychological Association has identified five levels of care that include intensive outpatient and partial hospitalization programs as steps up to bridge the distance from outpatient care to residential or full hospitalization. *See*, Yager, Joel & Devlin, Michael & Halmi, Katherine & Herzog, D.B. & III, J.E. & Powers, P. & Zerbe, K.J. (2006). Practice guideline for the treatment of patients with eating disorders third edition. *American Journal of Psychiatry*. 163. 1-128.

- Clinical trials have demonstrated that day treatment programs are more effective than traditional outpatient treatment with outcomes similar to residential treatment. *See*, Hepburn, Z., Wilson, K. (2014). Effectiveness of adult day treatment for eating disorders. *Mental Health Review Journal*, 19(2), 131-144. 10.1108/MHRJ-01-2013-0003.

- Partial hospitalization programs are a cost-effective alternative to residential programs for patients with an acuity too high for traditional outpatient care. *See*, Hayes, N. A., Welty, L. J., Slesinger, N., & Washburn, J. J. (2019). Moderators of treatment outcomes in a partial hospitalization and intensive outpatient program for eating disorders. *Eating disorders*, *27*(3), 305–320. 10.1080/10640266.2018.1512302.

- Day programs enable patients to encounter everyday life situations that can impact eating choices, enabling patients to practice and develop better long-term coping behaviors. *See*, Zipfel, S., Reas, D.L., Thornton, C., Olmsted, M.P., Williamson, D.A., Gerlinghoff, M., Herzog, W. and Beumont, P.J. (2002), Day hospitalization programs for eating disorders: A systematic review of the literature. *International Journal of Eating Disorders*, 31: 105-117. https://doi.org/10.1002/eat.10009.

One exhaustive review paper assessed the effectiveness of day treatment programs for adults with eating disorders by comparing, evaluating, and synthesizing published pre- and post-treatment outcomes and concludes: "This review aimed to evaluate the effectiveness of DTPs [day treatment programs] for eating disorders in relation to BMI, binge/purge and vomit symptoms, anxiety, depression, self-esteem and eating disorder psychopathology. There is strong evidence that DTPs are effective in improving all these variables among adults with eating disorders. Moreover, RTCs [randomized control trials] have demonstrated DPTs to be more effective than outpatient treatment and of similar effectiveness as inpatient care at enabling patients with eating disorders to make improvements."[7]

Another study examining a large sample of patients concluded, "Partial Hospitalization Programs (PHP) are a critical part of the treatment continuum for people with eating disorders. PHPs provide an alternative to costly and restrictive inpatient and residential programs while offering more intense treatments for patients too acute for traditional outpatient services. . . . the findings add to the literature supporting the effectiveness of PHP for a wide range of eating disorders."[8]

[7] Hepburn, Z., Wilson, K. (2014). Effectiveness of adult day treatment for eating disorders. *Mental Health Review Journal*, 19(2), 131-144. 10.1108/MHRJ-01-2013-0003.
[8] Hayes, N. A., Welty, L. J., Slesinger, N., & Washburn, J. J. (2019). Moderators of treatment outcomes in a partial hospitalization and intensive outpatient program for eating disorders. *Eating disorders*, *27*(3), 305–320. 10.1080/10640266.2018.1512302

In the context of the lack of care for eating disorders in the state of Vermont, we would also like to point out that there is ample evidence that the longer patients wait to receive treatment, the worse the treatment outcomes will be.[9] This is commonsensical, of course, the longer patients have to wait for treatment, the worse the disease and outcomes will be and the more expensive it will be to treat them. More importantly, we believe, is the prolonged suffering that those with eating disorders have to unnecessarily endure.

One point worth noting in the literature is the following benefit of IOP and PHP programs compared to 24hr care. "In addition to financial benefits, day programs have important clinical advantages over inpatient care. Day hospitalization allows the patient to maintain some social and vocational role, thus encouraging more independence than inpatient treatment. Additionally, the non-removal of patients from their natural environment is conducive to the transfer of therapeutic gains. Thus, new skills learned in treatment can be better generalized by their immediate application within the patient's home environment. Because the patient spends nights and weekends away from the hospital, day programs also allow greater family contact and support… Further, while remaining at home or at school or work, patients are exposed to the psychosocial situations that may have played a role in maintaining the eating-disordered behavior (family conflict, peer relations, eating at school, diet products being in the house). Repeated exposure to these situations allows the patient to develop alternate coping behaviors that can be developed and rehearsed within the group setting."[10] (Zipfel et al. 2002) This is a distinct advantage that residential and inpatient care cannot offer, since patients are entirely removed from their normal environment and have no opportunity to work through their issues in their natural environment as they arise. Indeed, there is data showing that patients discharged from PHP care do better than those discharged from 24hr care.[11] Furthermore, this aligns with the Act 79 Report: "A strong system of care requires services and supports across the spectrum of health promotion and prevention, early intervention, and intensive intervention in settings where children and families spend their time."(p. 79)

The mainstay of our treatment methodology will be CBT and DBT therapy. There is an abundance of empirical evidence supporting these treatment methodologies in general as well as in eating disorder treatment.[12] They are the standard treatment methods used in most existing PHPs and IOPs.

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[9] Austin, A., Flynn, M., Richards, K., Hodsoll, J., Duarte, T. A., Robinson, P., Kelly, J., & Schmidt, U. (2021). Duration of untreated eating disorder and relationship to outcomes: A systematic review of the literature. *European eating disorders review: the journal of the Eating Disorders Association*, *29*(3), 329–345. https://doi.org/10.1002/erv.2745

[10] Zipfel, S., Reas, D.L., Thornton, C., Olmsted, M.P., Williamson, D.A., Gerlinghoff, M., Herzog, W. and Beumont, P.J. (2002), Day hospitalization programs for eating disorders: A systematic review of the literature. *International Journal of Eating Disorders*, 31: 105-117. https://doi.org/10.1002/eat.10009

[11] Hepburn and Wilson, 2014.

[12] Ibid.

Intensive outpatient and partial hospitalization programs as a part of a spectrum of care levels for eating disorders is well-recognized in the mental health provider community and there is substantial research demonstrating the efficacy of the programs and the ability to obtain good outcomes at a lower cost. In addition, the Kahm Clinic will seek Joint Commission Behavioral Healthcare Standards accreditation to ensure high quality care.

Requested Rates

In an email from Tonya Corrigan on February 9th, we were given the following rates: S9480 - $xxx per diem/unit (IOP) and H0035 - $xxx per diem/unit (PHP). We request the rates of $xxx for S9480 and $xxx for H0035. The requested rates are conservative averages that we have seen from single case agreements with other Vermont insurers.

We will not be able to take Medicaid at the rates that you proposed to us, because we will not be able to ensure the financial stability of the program, pay our staff adequately, as well as keep the quality at a high enough level.

We do hope that you will be willing to pay sufficiently for the services rendered.

P.S. WCAX just did a good piece on the need for treatment in VT:

https://www.wcax.com/2022/03/24/does-vermont-have-enough-eating-disorder-treatment-youth/

Best,

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